NEW PRODUCT ADVISORY No. 03-004

A DENTAL PLAN'S COPAYMENTS

ACTION: Review Concluded March 14, 2003

Amendment proposing a new subscriber product consisting of three contracts with changes in benefit designs and copayments utilizing a previously approved provider network.

Filing Nos. 20022851 and 20023307
Filed November 11, 2002 and December 24, 2002

SUMMARY

A particular Dental Plan proposed a new dental subscriber product consisting of three contracts ("LC Series"), about which the Department inquired whether the copayments were excessive, resulting in the Plan not assuming full financial risk on a prospective basis, as required by Section 1375.1 of the Knox-Keene Health Care Service Plan Act of 1975, as amended (the "Act"), (Health and Safety Code section 1340 *et seq.*). Additionally, excessive copayments would violate Sections 1367(d), (e) and (h) of the Act.

Based on the particular Plan's proposed new dental subscriber product, the Plan was permitted to implement the proposed product, subject to any future review and revision that may be necessary.

BASIS OF ACTION

The Department required the particular Dental Plan to address a variety of issues, including whether the copayments resulted in the Plan being in violation of Section 1375.1 of the Act and violated Section 1367(h). The Department determined that for services necessary to maintain dental hygiene and health, documents submitted in connection with the Plan's proposal substantially comply with the Act. In addition, the particular Dental Plan provided information about copayments for orthodontic services, which would have been considered objectionable (as excessive) had they been attached to necessary services.

The particular Dental Plan compensates general dentists with a combination of capitation, procedure supplemental payments, and chair hour guarantees. Specialty dentists are compensated through discounted fee-for-service payments. The particular Plan's fees to providers may be locality adjusted. The particular Dental Plan represented that 66.4% of all aggregate costs for dental services covered by the Plan is paid by the Plan, and that only 33.6% of total compensation paid to Plan dentists across its book of business comes from enrollee copayments. Corresponding projections, based on benefit design and expected utilization, for the three contracts filed range from 65.6% to 73.7% paid by the particular Dental Plan and from 26.3% to 34.43% paid through enrollee copayments. The aggregate cost information and

corresponding projections, by themselves, were insufficient to establish compliance with Section 1375.1.

The particular Dental Plan provided data for each of the three contracts showing that for each of the covered services, except for certain orthodontic procedures, the copayment was 50% or less (in most cases significantly less) than the California average cost of the particular service or procedure, based on information provided by an independent, nationally recognized company which gathers and publishes data about fees that dentists routinely charge. Because the information provided by the particular Dental Plan showed that, except for certain orthodontic procedures, the copayments for each service in the product filed were in substantial compliance with the provisions of the Act cited above. The Department found it unnecessary to require that the copayments be compared to costs set forth separately by zip code or region of the state.